SHOP Marketplace
Health Insurance for Small Businesses

04/2016

Form Approved
OMB No. 0938-1213

Instructions to help you complete the SHOP Employee Eligibility Appeal Request Form

Use the right form to request an appeal

- This form is for employees of businesses that participate in the Small Business Health Options Program (SHOP) Marketplace.
- If you applied for your employer's SHOP Marketplace coverage and were denied, you can request an appeal.
- Some states operate their own SHOP. If you're not sure this form is the right one for you, visit HealthCare.gov/small-businesses/ to learn more about your state's SHOP.
- Visit HealthCare.gov/marketplace-appeals to learn more about Marketplace appeals.

Timeframe to request an appeal

We must receive your appeal request **within 90 days** of the date on the SHOP eligibility determination notice that you're appealing.

How to submit this form

Complete and sign this form, and mail it with **copies** of any supporting documents to:

SHOP Marketplace Appeals
Health Insurance Marketplace
465 Industrial Blvd.
London, KY 40750-0061

Keep a copy of all forms for your records.

How to submit additional information

You may submit additional information along with this Appeal Request Form to support your appeal. Send copies only. Keep all original documents. We'll consider all timely information when making a final determination. Submit all available information when you send this Appeal Request Form.

What happens next?

1. **We'll contact you.** We'll send a notice to let you know that we got your appeal request. It will explain the appeal process, and give you instructions for sending additional information, if needed. You'll have 15 days from the date of this notice to send any additional information if it's required. If there's a problem with your appeal request, like if it's missing information, we'll tell you how to correct the issue. We'll also tell your employer about your appeal request. Your employer can submit information to support your appeal.
2. **We'll review your information.** Your appeal request will be reviewed along with the information used by the SHOP Marketplace to determine your eligibility.
3. **We'll send a decision about your appeal.** A final decision will be mailed to you and your employer within 90 days of when we get your appeal request.

Additional help

Language assistance services
If you need help in a language other than English, you have the right to get help and information in your language at no cost. Call the SHOP Call Center at 1-800-706-7893. TTY users should call 711 to reach a call center representative. Hours of operation are Monday through Friday, 9 a.m. to 7 p.m. Eastern Time (ET).

Accessibility
To request an auxiliary aid or service, you can:

- Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676.
- Send a fax to 1-844-530-3676.
- Send an email to: **AltFormatRequest@cms.hhs.gov**
- Use this address only to send a letter requesting an auxiliary aid or service:
  Centers for Medicare and Medicaid Services
  Office of Equal Employment Opportunity & Civil Rights (OEOCR)
  Attn: CMS Alternate Format Team
  7500 Security Boulevard, Mail stop: N2-22-16
  Baltimore, MD 21244-1850

To submit your appeal request, see **How to submit this form** on page 1 of these instructions. Don't use **Accessibility** contact information to submit an appeal request.

Choose an authorized representative

- You may have a relative, friend, legal counsel, or another spokesperson, including an authorized representative, help you make an appeal request or participate in your appeal. This is optional. If you choose to have an authorized representative, you're giving this person permission to talk with us about your appeal. The authorized representative, if you choose one, will be the primary contact for all notices and information related to your eligibility appeal.
- To appoint an authorized representative, complete and mail the form "Appoint an authorized representative for my appeal," available at **HealthCare.gov/marketplace-appeals/getting-help/**.
- If there's more than 1 authorized representative for the individual who's submitting this appeal request, complete a separate "Appoint an authorized representative for my appeal" form for each authorized representative.

Questions

For more information, visit **HealthCare.gov/small-businesses/**, or call the SHOP Call Center at 1-800-706-7893. TTY users should call 711. Hours of operation are Monday through Friday, 9 a.m. to 7 p.m. ET.

Privacy and Use of Your Information
The Marketplace protects the privacy and security of information about you that you've provided. To view the Privacy Act Statement, go to **HealthCare.gov/individual-privacy-act-statement/**. We're authorized to collect the information on this form and any supporting documentation, including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111–152), implementing regulations in 45 CFR part 155, subpart F, and the Social Security Act. For more information about the privacy and security of your information, visit **HealthCare.gov/privacy/**.

Paperwork Reduction Act Disclosure Statement
According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1213. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SHOP Employee Eligibility Appeal Request Form

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SHOP Appeal Request Form – Employee

Please print in capital letters using black or dark blue ink only.
Fill in the circles (○) like this → ●.

SECTION 1: Employee information.

This should be filled out by the person requesting the appeal, or by an authorized representative.

1. Name of person who was denied SHOP coverage (First name, Middle name, Last name)

Date of birth (mm/dd/yyyy)

What date did your employer choose for SHOP coverage to start? (mm/dd/yyyy)

Employee's street address

Apartment or suite number

City

State

ZIP code

Daytime phone number

Email address (optional)

2. Employer

Employer's mailing address

Apartment or suite number

City

State

ZIP code

Employer's phone number

Employer ID Number (EIN) (optional) This can be found on your W-2 form.

SECTION 2: Reason for this appeal.

Your eligibility determination notice explains if you're eligible for SHOP coverage offered by your employer. You can appeal the eligibility determination for either of these reasons:

- You weren't eligible to enroll.
- You think that the SHOP didn't provide your eligibility determination in a timely manner.

If your employer wasn't eligible to participate in the SHOP, you can't appeal that decision, but your employer can.

Date of eligibility notice (located on the upper right corner of the notice) (mm/dd/yyyy)

Explain the reason for your appeal. Your explanation should include the reason you think we made a mistake. Add more pages if needed. If you're including documents to support your request, send us copies. Keep all original documents.

SECTION 3: Signature

This information applies for all individuals signing below who are 18 or older.

I'm signing this form under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

Signature of person requesting an appeal (or authorized representative, if applicable)	Date (mm/dd/yyyy)
	/ /

Printed name (First name, Middle name, Last name)